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AUTHOR Sawicki, Donna
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ABSTRACT

The document describes the Family Treatment Unit, a demonstration program to provide a variety of family treatment services to status offenders (11 to 17 years old) and their families. The goals of the program are: (1) to provide family services to families of status offenders; (2) to maintain status offenders in their natural homes by strengthening the family system; (3) to reduce the rate of referral to the court; (4) to provide training to actual and potential foster parents; and (5) to enhance knowledge of family therapy among the court's juvenile justice staff. Three levels of service are provided--consultation and training to juvenile court personnel, assessment and skills development training of new foster parents, and family therapy of either a relatively brief, intensive nature or an ongoing weekly sort. Evaluation data indicate that the unit has been successful in meeting its major objectives. Among appendixes are sample referral forms, evaluation instruments and examples of family assessment statements. (SBH)

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FAMILY TREATMENT UNIT

St. Louis County Juvenile Court

501 South Brentwood Avenue

Clayton, Missouri 63105

314-889-3000

Dr. Donna Sawicki, Project Director

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PROJECT PERSONNEL

Project Director - Donna Sawicki, PhD, Psychology

Project Coordinator - Marie Dargin, MSW

Research Assistant - Beatrice Schaeffer, M.A. Student in Program Evaluation

Therapist/Social Worker II - Lawrence Cohen, MSW, M.A.,Sociology, 2 years post graduate training in family therapy

Therapist/Social Worker II - Sarah Griffin, MSW, student in advanced training in family therapy

Therapist/Social Worker I - Susan Oldham, MSW

Therapist/Social Worker I - Craig Voorhees, M.A., Psychology

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LIST OF ACRONYMS AND ABBREVIATIONS

DJO - Deputy Juvenile Officer

FTU - Family Treatment Unit

HIFT - High-Impact Family Treatment

JBC - Jessness Behavior Checklist

INTRODUCTION

Established upon the principles of humanitarian concern and differential treatment, the juvenile court is unique in its operation in that it is both a legal and social service agency - a court system which emphasizes care and treatment as opposed to punishment. In addition to dealing with juveniles accused of offenses analogous to adult misdemeanors and felonies, Missouri juvenile courts have jurisdiction over status offenders. These offenses are unique to juveniles and include such behavior as running away, incorrigibility, truancy, and curfew violations.

Throughout the last decade many observors of juvenile justice as well as juvenile justice personnel have suggested that special treatment services and facilities should be provided for such juveniles. The Family Treatment Unit of the St. Louis County Juvenile Court was established in an attempt to provide more effective services to status offenders and their families, treatment designed to meet their particularized needs.

This document is an introduction to the Family Treatment Unit, the philosophy which underlies the treat ment program, as well as a detailed explanation of the program components and the everyday workings of the program. It is intended as a replication model to assist other agencies serving juveniles through family therapy. It also explicates the program's relationship with other components of the Juvenile Court and its service to foster families dealing with status offenders.

BACKGROUND MATERIAL

The Family Treatment Unit of St. Louis County Juvenile Court was established in 1977. Presently entering its third year of operation, the program functions as a service component within the Juvenile Court of St. Louis County, a metropolitan area which excludes the City of St. Louis. The Unit is designed to provide a variety of family treatment services to status offenders and their families. Eligibility is limited to families of those youths whose initial referral to the court or first adjudicated offense was a status offense. Additionally, the Unit serves a foster care program by providing assessment of foster families and skills development training to foster parents and serves court personnel via consultation and training.

The emergence of the FTU was the result of several factors. A major influence was the growing belief in the field of juvenile justice and corrections that status offenders ought not be treated as criminally delinquent. More specifically, court personnel in St. Louis County along with authorities nationally felt that these children should not be placed in institutions whenever this could be avoided but rather an effort should be made to maintain them in their own homes while seeking therapeutic remedies for whatever unhealthy or maladjusted circumstances had provoked the status violation. The growing number of status offense referrals to the court, numbering 3,408 in the year preceding the program's commencement, fueled the belief that alternative action needed to be taken by civil authorities responsible for the administration

of juvenile justice. In 1976, 292 status offense children had been placed in living situations outside their homes -- 147 of them in institutions. This was the situation that the FTU sought to alter.

Past experience of court staff members was also influential in the formation of the new program. Therapists working within a former court unit, the Intensive Treatment Unit, were often called upon to deal with the problems of status offenders. Many felt that the individualized therapy approach used within the unit was not thoroughly successful with status offenders because of its inability to deal with dimensions of conflict within the family. Treatment of the entire family was implemented experimentally as an alternative approach to dealing with clients. At the end of the last funding year for the older unit, court personnel felt that the initiation of a court service based primarily upon the family treatment model would be more successful in meeting the needs of status offenders.

Formerly, referrals for family treatment were directed toward service agencies within the community. Followthrough by families was minimal, estimated as low as ten percent. The designers of FTU felt that if family therapy were available within the court structure a higher percentage of families referred would follow through and thus receive the necessary services. This provided further impetus for the creation of the Unit.

Original funding for the Unit was provided in 1977 by the Missouri Council on Criminal Justice under the Juvenile Delinquency Prevention Act of 1974. All personnel working in the Unit are

paid through this funding with the exception of the Unit Supervisor who is a full-time employee of the Juvenile Court paid through county funds. During the first two years of the program's operation St. Louis County was required by the Council on Criminal Justice to match state funds on a one to ten basis: in the third year of operation this match is no longer required.

PROGRAM PHILOSOPHY AND OBJECTIVES

The Family Treatment Unit was established on the assumption that, particularly in the case of status offenders, it is often the limited coping abilities of the family as a unit that bring the incorrigible, truant or runaway youth into the juvenile court. While a status offense is an individual violation, it is usually also a signal of distress in the family. Accordingly, offensive juvenile actions are seen not as stemming from deficiencies within the juvenile himself/herself but as related to dysfunctional patterns of relating and communicating in the youth's family. And therefore, family therapy is believed to be an effective remedy to the family dysfunctions associated with these problems. Family therapy aims at rebuilding and restructuring the family relationships so as to alter the dysfunctional patterns and facilitate the successful functioning of the child within the family.

Because the family is thought to be at the heart of the status offender's problem it is thought that it is best - for the juvenile and for the functioning of the juvenile justice system - that the juvenile remain in his/her home. Removing the child from the home does not repair the underlying disruption that provoked the delinquent behavior in the first place. While placement may provide a temporary respite from a crisis situation, if the family has not developed coping strengths, problems will re-emerge when the child is returned. Family theapy is believed helpful to families in developing the coping strengths needed for maintenance of an intact family unit.

When, however, the child's removal from the family is deemed best for the child's welfare, foster care is the favored mode of placement for status offenders. De-institutionalization of status offenders, a policy promoted by the Juvenile Delinquency Prevention Act of 1974, is directed at developing alternative living situations which most closely resemble the traditional family. Foster care today provides the most viable surrogate family. However, families willing to provide care to status offenders are always in short supply and, because of lack of training, they often grow disillusioned about their ability to help children in trouble. The result, in many cases, is that these families withdraw their assistance or ask that particular children be removed from their care. The child who is shifted from family to family becomes a victim of the system designed to act in his/her best interest and is often further alienated from society. Proper training for foster families in the care and treatment of problem children is believed helpful in keeping foster parents enthusiastic and effective components of a juvenile welfare program.

The overall goals of the Family Treatment program are a reduction in the number of placements in state correctional schools, institutions, in private and court-operated group homes, and a reduction in escalating delinquency patterns of status offenders. These two broad and general goals are captured in the following set of specific objectives:

1) to provide family services to families of status offenders.

2) to maintain those status offenders served by the FTU in their natural homes by strengthening the family system.

3) to reduce the rate of re-referral to the Court of status offenders served by the FTU.

4) to provide training to actual and potential foster parents.

5) to enhance knowledge of family therapy among the court's juvenile justice staff.

ORGANIZATIONAL DESCRIPTION

The Family Treatment Unit functions as a component of the St. Louis County Juvenile Court, an urban, county-supported agency serving the suburban and metropolitan areas encircling the City of St. Louis. In 1977 the population of St. Louis County was 988,795. In this same year the Juvenile Court received 10,515 delinquency referrals. Approximately one-third of these were status offense referrals. Referrals to the Family Treatment Unit do not come directly from law enforcement officials or community members. Rather, status offenders referred to the Unit have been screened by court personnel. Deputy Juvenile Officers in Intake, Court Community Services, Supervision Units, and the Neglect and Special Services may make referrals. In some cases a family is ordered to enter therapy by a Court Presiding Officer (the juvenile judge, commissioner, or hearing officer).

The FTU is officially administered by the Project Director who is a member of the Court staff and who has responsibility for another program within the system. The day to day operation of the program is handled by the Project Coordinator (Unit Supervisor) who develops and implements treatment activities. The Coordinator directly supervises the social work staff and assistants. He/she screens and assigns cases, coordinates staff activities and liaison activities with the court staff. This individual shares personnel recruitment and

hiring responsibilities with the Project Director.

Four social workers work under the direction and supervision of the Coordinator. They are divided into two ranks according to experience. Social Workers II (two positions) provide direct treatment services (both assessment and therapy), provide clinical supervision for graduate practicum students, lead training sessions for court personnel and foster parents, and collect research data for program evaluation. Social Workers I (two positions) have nearly the same responsibilities except for the supervision of social work practicum students.

The Unit has a half-time Research Assistant who assumes the major responsibility for the research component of the program. This individual oversees the collection and analysis of data pertaining to FTU clients as well as a control group of families under regular Court supervision but not receiving FTU services. FTU also employs one secretary/receptionist who types reports and letters, schedules appointments, and maintains case records, as well as performing routine office tasks.

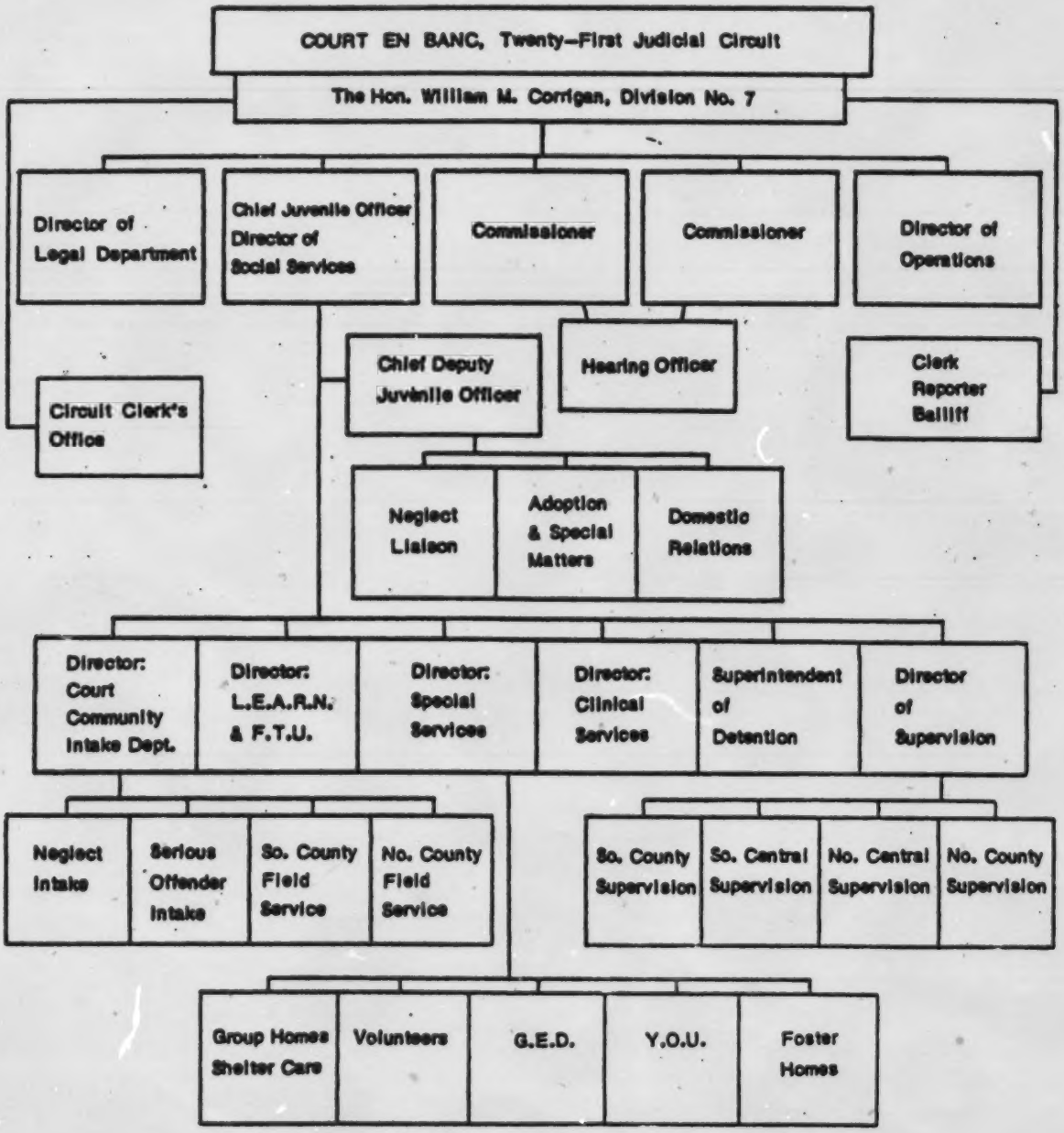
The primary liaison responsibilities of the FTU personnel pertain to other Court staff members. They do not routinely have dealings with agencies outside the Court. The Deputy Juvenile Officer assigned to the status offense case is in charge of the overall case maintenance and is thus responsible for making and maintaining relationships with cooperating agencies, if necessary.

FIGURE 1: Organizational Structure of Family Treatment Unit

Administrative Structure

CIRCUIT COURT JUDGES – 21st JUDICIAL CIRCUIT
ST. LOUIS COUNTY, MISSOURI – APRIL, 1979

The Hon. William H. Crandall, Jr.	Division No. 1	The Hon. Edward L. Sprague	Division No. 11
The Hon. Harry J. Stussie	Division No. 2	The Hon. Ninian M. Edwards	Division No. 12
The Hon. Richard T. Enright	Division No. 3	The Hon. John R. Rickhoff	Division No. 13
The Hon. Herbert Lasky	Division No. 4	The Hon. James Ruddy	Division No. 14
The Hon. Arthur Litz	Division No. 5	The Hon. Robert Lee Campbell	Division No. 15
The Hon. Franklin Ferriss	Division No. 6	The Hon. Orville Richardson	Division No. 16
The Hon. Robert G. J. Hoester	Division No. 8	The Hon. Milton A. Saitz	Division No. 17
The Hon. George W. Cloyd	Division No. 9	The Hon. Philip J. Sweeney	Division No. 18
The Hon. Drew W. Luten, Jr.	Division No. 10	The Hon. Melvyn W. Wiseman	Division No. 19
		The Hon. Louis M. Kohn	Division No. 20



PROGRAM COMPONENTS

Three levels of service are provided by the FTU: 1) consultation and training to Juvenile Court personnel, 2) assessment and skills development training of new foster parents, and 3) family therapy of either a relatively brief, intensive nature or an on-going weekly sort.

Therapy

Referrals for family therapy are accepted on families of status offenders from Deputy Juvenile Officers (DJO) in Intake, Court Community Services, Supervision, Neglect and the Special Services Units. Referrals are accomplished by the completion of a FTU referral form (see Appendix) which includes basic information on the family, a DJO questionnaire, a Jesness Behavior Checklist (used for research purposes) and a consent form for research. These forms are forwarded to the Project Coordinator who reviews them, discusses them with the referring DJO if necessary, and assigns the case to a worker in the Unit. All referrals are assigned within one working day whereupon the referral source is notified by memo as to whom the case has been assigned. (see Figure 2)

Approximately 90% of referrals received by FTU are from DJOs based on their decision that the root of the status offender's problem is within the home situation. DJOs look for family communications difficulties, marital troubles and general family instability in making a decision whether a particular family is appropriate to refer to FTU for therapy. Approximately 10% of

of FTU cases have been ordered to enter therapy by a court presiding officer, either judge, commissioner, or hearing officer. In the latter case the court order often reflects an agreement reached between the DJO and family, but it sometimes happens that a family is ordered into therapy without consenting to it. Usually when an court officer orders therapy the order follows a discussion with a DJO, however, this need not be the case. The presiding officer may order that an assessment of family functioning be performed by FTU personnel and that a report be made to him/her. Sometimes, the presiding officer will strongly urge a family to consider therapy but will stop short of ordering that they do so.

The ongoing family therapy conducted by FTU services a unique clientele, for therapists feel the Unit receives the most difficult cases within the Court, those which other personnel have found difficult if not impossible to handle. Likewise, many of the families have been involved in unsuccessful programs within the community, including psychological, psychiatric, and family therapy programs. These families are highly resistant to change and are characterized by a high degree of unresolved family conflicts, often of a longstanding nature. The nature of the referrals necessitates rapid assessment by the therapist and flexibility in the planning of treatment strategies. Most crucial is the ability to consider and implement a variety of approaches in attempting to establish a therapeutic relationship.

The therapist assigned a case makes the initial contact with the family within three working days of receiving the case in order to schedule an appointment for the first interview. During the first one or two sessions the worker's primary goal is to understand the family's problems and to develop with them an appropriate treatment plan. (see Appendix for a sample treatment plan). Each therapist is available two evenings a week for the convenience of clients who are unable to keep daytime appointments. Services are delivered for the most part at the Juvenile Court facility, but arrangements can be made to meet with families who live in outlying parts of the County at one of two branch offices. Therapists do not visit clients in their homes.

Two modes of family therapy are offered; both aim at providing treatment to entire families of status offenders. It sometimes happens that one or more family members is reluctant to join therapy. DJOs are trained to present the program to families of status offenders in such a way as to make it clear that therapy is intended for all family members. Once a family has begun therapy the therapist does not pressure absent family members to rejoin the sessions but relies on the other family members to do so.

After the initial one or two meetings with a family, when a treatment plan has been developed, the therapist notifies the DJO of the plan. Ideally the plan encompasses family members' goals for therapy as well as the therapist's professional assessment and goals. If the plan involves selection of the on-going mode of

therapy the therapist will begin meeting with the family on a weekly basis in sessions of one hour. In some cases treatment will involve two therapists working as a team although this is not usually the case. The average duration of the on-going mode of therapy is 3 1/2 months but it sometimes continues for as long as 7 months in an effort to meet the goals set out jointly by the family and therapist.

An alternative to weekly therapy is the "multi-impact" mode which is accomplished in six weeks and is found especially helpful in treating resistant families. At least four therapists are involved simultaneously in working with one family. High-impact family treatment (HIFT) begins with an initial meeting in which the treatment team explains to the family what is involved. The sessions begin not more than one week later. For the first three weeks three hour sessions are scheduled; for the second three weeks sessions last only one hour each. For ease of scheduling with the HIFT mode all therapists in the FTU leave one afternoon a week free.

High-impact therapy is designed so that all therapists can get to know a family in a short period of time. The entire process is video taped. While two therapists interview the family, the remaining two or three therapists watch through a one-way mirror. Then each family member meets individually with a therapist. An attempt is made to build alliances between a particular family member and therapist. Following this session the treatment team meets to outline possible therapeutic avenues. In the session that follows various role playing techniques are used, involving

the entire family and treatment team. Then "practice sessions" are held wherein family members try out new roles with one or more co-members. Often the family views parts of the video tape. In the final sessions all the family and team meet to assess the treatment experience. (See Appendix for journal article discussing this form of therapy.)

Several modifications of the program were made in its second year of operation. One of the treatment modes - the High-Impact mode - was redesigned to be less intensive. Treatment was spread out over a six week span rather than two days. The therapeutic staff found the original design to be overly demanding to themselves and an insufficient time for the development of and incorporation of therapeutic experiences on the part of the families involved. Two positions filled the first year were eliminated, those of psychologist and psychometrist. Individualistic psychological testing was found to be unnecessary, especially inasmuch as it is designed to assess individual behavior, capability and personality structure whereas family therapy focuses on the relationships of individuals. Therapists found that they could acquire all necessary information about family members from their interviews and interaction with the family. The Unit spent less time than anticipated dealing with foster families because of a decline in the court's foster care program, but the Unit became involved in foster parent orientation and assessment for newly recruited families. Training of Court Staff in Family Therapy and related matters assumed a larger role than originally expected due to extensive staff needs and interests which had not been fully understood at first.

A family may drop out of therapy; when this happens the FTU makes a report to the DJO assigned to the case and it is the DJO's responsibility to decide what action to take. The therapist may, however, make recommendations to the DJO based upon his/her assessment of the family's ability to function. In some cases the therapist may feel that placement of the juvenile is necessary. If a juvenile is involved in further status offenses or is referred to the court for a misdemeanor, or even a felony, during the course of family therapy this does not automatically interrrupt the treatment plan. The therapist does hold responsibility for responding to all crises of a family in therapy when a family member contacts him/her. Therapists in the FTU maintain an average caseload of 12 families.

Consultation and Training

The FTU staff provides a series of training programs for Court staff and practicum students. Training focuses on specialized areas of family therapy pertaining to working with families of status offenders. Topics in 1978 included Practice of Family Therapy, High-Impact Model, Dealing with Resistance, and Women as Therapists. All Unit staff are available for consultation with Court staff upon request. In addition each staff person is assigned to specific Court Community Service and Status Prevention units to meet that unit's training and consultation needs on a regular basis. The unit worker is available to spend a minimum of 1/2 day a week in planned sessions with assigned units.

Foster Parent Training

The FTU is presently involved in providing two services to the Court Foster Home Program. Therapists assess prospective foster parents in one or two sessions held at the Juvenile Court facility or in the family home. The objective is to determine whether a family would make an appropriate foster care resource. The unit personnel also aids the Foster Parent Coordinator in foster parent skill development programs. In the past year FTU has participated in two four-week training session of this nature, training approximately ten foster families.

Record Keeping

After a referral is received and reviewed by the Project Coordinator, it is given to the secretary who makes a treatment file and gives it to the assigned worker. The file includes the referral form and any additional information sent by the referring DJO. The inside cover of the file also includes a chronological events form which is used by the worker to record dates of family sessions and significant contacts with the DJO. The file also includes the Missouri Council on Juvenile Justice Statistical Form which is to be completed immediately by the assigned worker and given to the secretary who forwards it to the State Office. (See appendix for forms)

Within one week following the first or second family sessions, the worker completes a written assessment and specific treatment plan. The assessment and plan is reviewed by the Coordinator before being filed. A copy is sent to the referring DJO. Following this initial recording the therapist is responsible for preparing a written progress report for a Court Hearing or other case action upon the request of the referring DJO. When a worker terminates treatment a written closing summary is prepared and submitted to the Coordinator for approval. It is the practice of the Unit to dictate narrative records for transcription.

Research/Evaluation

The Unit is involved in on-going research and evaluation of family treatment services. A research file is established by the secretary for each case immediately upon receipt of the referral.

Two research measures are used with each family; these are the Jesness Behavior Checklist and the Moos Family Environment Scale. The DJO making the referral to FTU is responsible for getting a parent to complete the JBC during an interview at the Court. It is also the DJO's duty to have the family sign the consent form for research. If the Unit receives any forms incomplete, it is the responsibility of the therapist to obtain the additional information. The Moos Family Environment Scale is administered by the therapist during the initial interview with the family and also at the 4th and 12th week sessions. The JBC is also to be administered by the therapist at the 12th week. In addition to administering the above scales the therapist must complete Missouri Council on Juvenile Justice statistical forms on assigned families.

Relationship with DJOs

The assigned family therapist may discuss the family situation with the referring DJO prior to making contact with the family and is expected to keep the DJO informed of treatment plans, assessments, any changes in treatment, as well as of any difficulty the family may have in following through with therapy.

The DJO may contact the family therapist at any time during the treatment process for a progress report or to discuss any concerns he/she may have about the family or about treatment. The DJO is free to sit in on an interview or to act as co-therapist. Cases cannot be closed by therapists without a prior discussion

with the referring DJO. When a case is closed a copy of the closing summary, including the reasons for closing is sent to the DJO. Note that in situations where a family fails to keep four appointments in a row the worker closes the case unless otherwise cleared with the Project Coordinator.

The DJO maintains primary responsibility for the status offense case even while the family is in therapy. The DJO deals with any new referrals and with relations with outside agencies. Termination of a family therapy case is not necessarily coterminous with closing of a status offense case. The DJO may or may not maintain contact with the juvenile on whom the status offense report was originally received while the child and his/her family undergoes therapy; however, it is unlikely that the DJO will do so when the child has not been placed under court jurisdiction.

Relationship With Court

Should a child in therapy be required to come before the court for possible adjudication while a family is in therapy a FTU therapist may be required to attend the hearing to testify, and/or to provide written reports to the court. Requests may be made by either DJOs or presiding officers. It is common for therapists to inform families that they have been asked to attend a hearing and to notify families of the recommendations they are likely to make regarding the disposition of the child. This is done in an attempt to maintain the therapeutic relationship with the family. Therapy sessions are not regarded as confidential in the eyes of the court.

Skills of Staff

The Unit is staffed by workers with graduate degrees and specific training and experience in family therapy. Social workers (family therapists) have MSWs or Master's Degrees - SWIIs have three years experience in family therapy practice - the SWI is not expected to have this experience but should have some academic and practical training in this area. Social Work assistants are graduate or undergraduate students in social work or counseling programs.

POPULATION SERVED

During the second year of operation 185 families were referred to the Unit for services. The ages of the delinquent children receiving services ranged between 11 and 17 with 81% falling in the 16 to 17 age range. (The average age of the child served by the court is 14.7 years.) Approximately 50% of the FTU clients were males and 50% were females. Only 2% of the families served were black, the remaining 98% being white. Thus, black families were underrepresented in the population because they constitute 35% of referrals courtwide. The reason for this discrepancy is unknown, although referring court personnel (juvenile officers) have indicated that they feel black families would be less responsive to the service.

With respect to the composition of families, 25% of them have three or less members, 26% have four members, and 49% have six or more members. Two-parent families represent 63% of the clients served with the remaining 37% being single-parent units.

Children receiving services average three offenses per child at the time of referral to the Unit, with approximately 60% of these offenses being status offenses and 40% misdemeanor or felony offenses. Post treatment re-referral rates are less than one offense per child for families receiving services from the Unit.

EVALUATIONS

Attempts to evaluate the effectiveness of the Family Treatment Unit are integral to the design of the program. But due to the relative newness of the unit, evaluative efforts are currently incomplete. Partial data indicate that the FTU has been successful in meeting its major objectives. The following include an evaluation of the first year of funding and a preliminary analysis of the pre and four-week scores of Family Treatment Unit clients on the Family Environment Scale, an attitudinal measure of change.

Evaluation of First Year of Funding for Family Treatment Unit

This report is divided into two components. Section one presents evaluation data as related to the achievement of each specific objective originally stated in the Grant Proposal. Recommendations for revision of specific objectives are made on the basis of data presented. The second section of this report covers the preliminary findings of a three year evaluation design as described in the original grant proposal. This design involves repeated testing of families that have participated in the Family Treatment Unit. It also involves comparisons of recidivism rates between families served by the unit and a matched sample of families not receiving services.

Title Review of Objectives

Objective 1: To provide a systematic assessment of 150-200 children and natural families in cases where there is severe family disruption and placement is being considered.

As of July 31, 1978 there have been 191 families referred to the Family Treatment Unit. Family assessments have been completed on 135 families and were in progress on 16 families. In addition 41 families were served at the consultation level including the assessments in progress a total of 151 families have been assessed during this period. This number is within the parameters of the original objective as established in the grant application.

Objective 2: Family evaluation of 25-50 foster parents.

As of July 31, 1978 twenty foster parents or perspective foster parents have participated in the assessment process. This objective as stated in the original grant proposal has not been achieved. Failure to achieve this objective is in part due to the fact that the recruitment of foster families throughout the court has been less than projected. In addition the Family Treatment Unit has been successful in diverting children of families who referred to the unit for services from placement. Because of this, the involvement of the unit in foster family situations has not been as great as anticipated.

During the second year of operation this objective will be revised by activities reflected over the initial 12 month period.

Objective 3: To provide 12 hours of intensive multi-impact therapy to 26 natural families.

As of July 31, 1978 13 families have completed the High Impact Family Treatment Model. This is exactly half the number projected in the original grant proposal. During the initial year a good deal of staff time had been allocated to the development of the model itself, thereby decreasing the number of families to be served during the initial year. During this year

the High Impact Team has also participated in other teaching and training activities pertaining to the development and dissemination of this model. A taping on the High Impact Treatment Model has been accepted by the Juvenile Justice Journal to be published in February of 1979. Staff will be presenting on October 13, 1978 at the annual conference of Marriage and Family Counselors on the High Impact Model. There has been a revision and reworking of the treatment model. Teaching and training will also be part of the second year's activities. It is estimated that 20 families will participate in treatment model during the second year.

Objective 4: To train 50-75 foster family units by providing three five week workshops during the initial training year operation.

As of July 31, 1978 training had been provided to 27 foster family units. Training included both foster families who provide short term care for adolescents and families who provide ongoing longer term care for delinquent children. The number of foster families served was less than anticipated in the original grant proposal. Again recruitment of foster families was at a lesser rate than expected. The volunteer homes program which is a component of the status prevention grant had some start up difficulties and recruitment was slower than expected.

A summary of evaluation forms completed by parents who participated in the training is included in the appendix.

Objective 5: To provide weekly counseling during the initial months of foster placement for 50-75 surrogate family units.

This objective has not been met during the initial year of operation because the unit has been successful in containing the children within the natural setting therefore the need for counseling with foster parents and children has been less than anticipated. During the second year of operation emphasis will be on involving natural families in treatment with this objective de-emphasized.

Objective 6: To implement 75-100 treatment programs involving natural families.

As of July 31, 93 families had been involved in ongoing treatment and 16 families were involved in the initial stages of treatment. This objective has been exceeded during this funding cycle. It is anticipated during the second year of the program that 125 families will be involved in ongoing treatment.

Objective 7: To enhance the levels of services provided to status offenders and their families by training court staff in family therapy.

This objective has been added to those included in the original grant proposal because it was felt that a unit of family specialists would be a

valuable resource to the court staff in general by providing training and consultation to the broader court staff. As of July 31, 1978 the following training programs have been provided for staff and practicum students.

	Hours	Participants
Introduction to Family Therapy	13½	50
Consultation	90	2 staff per sessio
Student Training		
Session I	28	5
Session II	28	5
Women as Family Therapists	30	10

A summary of evaluation forms completed by participants in the introductory workshop is included in the appendix.

Publication

The article on the High Impact Treatment Model has been completed by the Project Staff and will appear in the February 1979 issue of Juvenile Justice.

Recidivism

Pre and Post treatment referral rates have been calculated on families receiving services according to origin of referral. These recidivism rates reflect referrals as of August 1, 1978.

Origin of Referral	# of Families	Average Number of Referrals Pre-Treatment	Post-Treatment
Special Services	3	2.67	.66
Neglect	3	4.00	.00
Intake	10	2.50	1.10
Supervision	39	5.13	1.64
CCS	46	3.02	.87
Total	101	Average 3.46	Average .85

As can be seen from the Table children of families who became involved in the unit show a considerable reduction in re-referral rates. An average of 3.46 referrals prior to entry into the unit and an average of .85 referrals post treatment.

Placements Outside of the Natural Family

Of the 191 families referred to the Unit for services a total of nine (9) children have been placed outside of their natural family units. Of these children one was placed in a Group Home, four were placed in a private residential

setting, and three were committed to the Division of Youth Services. Of these eight children only one had been involved in ongoing family treatment for longer than 6 weeks. It appears that the more involved family is able to become in the treatment process the less likely separation of the child from the family unit will occur.

Survey of Court Staff

In order to obtain feedback on the usefullness of the services of the Family Treatment Unit, a telephone survey was conducted on a sample of professional court staff members. It was felt that a telephone survey would be preferable to written questionnaires because this method would tap both users and non-users of the service and would not be biased towards those staff members holding favorable attitudes towards the unit. A total of thirty staff members were randomly selected from a personnel list utilizing a table of random numbers. Of those selected 28 were able to be contacted by phone. Results of the Survey are presented in the appendix.

Evaluation on Orientation

for Foster Parents

o what degree do you feel the workshop was a worthwhile learning experience for you?

waste											Extremely
f time	0	1	2	3	4	5	6	7	8	9	10 worthwhile

mments on above?

here was a total of 14 surveys that were filled out. The average rating was 6.5 ith two people rating it at "10", three people rating it at "8", five people rating t at "7", one person rating it at "6", one person rating it at "5", one person rating t at "3", and one person rating it at "2".

11 comments on the workshop were positive comments. The ones listed below summarize he general feelings of all who commented.

1) Hard to evaluate because had never had a child placed in their home.
2) Relief of anxiety and building of confidence in preparation for taking a child into their home.
3) Liked first hand experience from couple who had already experienced having a foster child in their home.

What discussions or activities represented a high point of interest and value to you?

1) Drugs, alcohol, etc.
2) Actual situations, real events or responses of people involved
3) Films
4) Book - "Suffer the Children"
5) First hand experience of Foster Couple

What discussions or activities represented a low point of interest and value to you?

Only 4 people responded to this question. The other 10 people felt that nothing was a low point of interest to them. In the four people who responded there was no consistency in their answers. Their responses appeared to be more of individual opinion vs. actual presentation.

What significant gains in understanding or skills do you feel you secured by participation in the orientation?

Two people answered that they did not gain anything. The other 12 people responded that they gained awareness of the child's individual needs, a sensitivity to the child's feelings, the idea that their home was to be a model home to the child, and they should not look to drastically changing the child.

Identify any positive and/or negative reactions you have regarding the trainer(s).

Both speakers were very honest, open and very easy to talk to, with a general feeling that both were very knowledgeable and that they were both very understanding people.

Any comments regarding schedule, etc.?

Few people commented on this - they did not like the fact that sessions were planned in winter - snow, etc. bad weather.

Evaluation or Orientation

for Foster Parents

What would you like with regard to future training?

1) more specific training on actual incidents which could occur.

2) monthly meetings or bi-yearly meetings to discuss problems that arise

3) more meetings to continue after child has benn placed in their home

4) more couples in group that already have foster children in their homes.

Other comments . . .

1) Shorter training to one long night or two short ones.

2) Give copy of "Suffer the Children" to all foster families.

3) Enjoyed program wished it were longer.

4) More people at meetings would make for broader discussions.

2 Surveys came back not filled out. One from Happy Kearns who could not attend on Wednesdays. One from Joe Rulo who attended once, but said they were too long, to attend any more, and did not fill out survey.

Attendance Of Sessions

Number of People Who Attended	Number of Sessions Attended
1	1
1	3
3	4
2	5
2	6
2	8
1	All
2	All but one
1	Most
1	Missed Last Few

ORGANIZATION OF WORKSHOP - Average 9

CONTENT OF WORKSHOP WAS RELEVANT/MEANINGFUL - Average 9

SPEAKER PRESENTATION: Average - 7.5

EXERCISES(ROLE PLAYING): Average - 7.5

OVERALL RATING - Average 8

(1) What area of the entire program was the most informative and useful to you?

A. Conceptual - 5
B. Techniques - 8 Both - 3

(2) Which part was the least relevant and meaningful to you?

A. Conceptual - 4
B. Techniques - 4 Neither - 2 Both - 3

(3) Were there areas not presented in your workshop which you feel should have been included?

Not everyone filled out this question. Below are the answers that were written in.

Present material according to levels of experience of staff.
More Interview Techniques by FTU staff.
More experience of working with/ a passive resistance and the family that glosses over trouble.
More Knowledge on HIFT, noval therapeutic modalities.
Discussion of Ethics
Continue w/family post initial meetings into - contracts. Gestalt, "homework" exercises, wrapping up.

(4) Would you recommend this program for future training of court personnel?
_____yes _____no

15 people answered yes. 2 people didn't check either way.

(5) How could the program be improved to be more effective in your work? Did you use what you learned in your actual practice? How or why not?

The general concensus of opinion and answer on this question was basically that they were using the techniques or trying to in their own therapy and were having good results.

(6) We observed that when the seminar emphasis switched from didactic presentation to role playing exercise that involved group members as therapists. attendance declined. Do you agree with this observation? If so. what alternative methods might you suggest? If you do not agree. what might you attribute the decline in attendance to?

Answers were about the same regardless of whether they attended most or 3 of the sessions.

They felt that role playing in a large group is intimidating and that may be why some people stopped coming.

Priorities in their own departments kept them from attending every week.

Seminars were far too long. Felt that much time was wasted towards the end and that more could have been covered in each session. Also felt each session each week should have been much shorter.

(7) Would you want to become part of a more advanced. intensive seminar?

10 people said yes. Of those 10 people the attendance was as follows: all, most, all but one, 8, 6 and 4 sessions.

One person said they would be interested only if smaller groups were used.
One person said they wanted to only if they could work as co-therapists
One person said they were not interested unless the seminar was held in a conference setting.

(8) General Remarks

Appreciated sharing of knowledge and information.

1. Have you used the services of FTU?

Yes___ Comments-why what motivated you to refer family?

No___ Why not?

2. Which services?

___Referral for Family Treatment and/or assessment(~~Frequently Decision to family~~)

___Consultation/Supervision for specific cases
Advice, insight from therapist re: a family w/out referring fam. for treatment

___Training Seminar

___Other

3. Have you been satisfied with the services you received?

Yes___ Comment

No ___ Why not?

4. What would make FTU a more useful resource for you?

What else would you like to see provided by FTU

5. Do you plan on using it in the future?

Yes___
No___ Why not?

6. Do you have any suggestions on how to improve this service?

Anything you would like to see changed

7. Any Comments?

Have you used the services of FTU?

19 Yes
Comments: Time Element - DJO doesn't have the time to get into intensive counseling
Court Oriented - Easy Accessability - More convenient for worker to refer to FTU than private agency.
Free - FTU is free counseling, appeals more to clients that cannot afford private counseling
Schedule - Evening hours make FTU very accessable for clients that cannot come in during the day.

No
Comments: Transportation - Clients from South County, North County, Etc. will not come into Clayton for services.
No Occasion To Use - Worker did not have status case, family refuse to come in, etc.
Appropriate Case - Worker had case that would be appropriate for FTU, but family decides to go a private agency.
Black Families are Different - Need different structure for Black Families
Uncooperative Family - Appropriate referral, but family will not cooperate with worker in trying family treatment with FTU

Which Services

19 Referral for Family Treatment and/or assessment

6 Consultation/Supervision for specific cases

13 Training Seminar

0 Other

Have you been satisfied with the services you received?

18 Yes. (10 people answered that they were satisfied with the contact between therapist and DJO)
(3 people said they wanted to know the progress of the case from the therapist - more feedback).

0 No (Hadn't used services, couldn't answer appropriately)

hat would make FTU a more useful resource for you?

More training sessions.
Better understanding of services, methods, therapy
Totally satisfied (1), Can't think of anything (2)
More involvement on part of DJO - Sit in on therapy - Co-therapy
Availability of FTU in South County, North County, etc.
Applicable to refer for more than just status offenses, neglect, other offenses
Keep evening hours
MOR: FTU only takes success cases!

o you plan on using it in the future?

26 Yes

1 NO (don't handle cases long enough) We don't accept Neglect, Abuse cases
This person also checked yes - not sure didn't know.

o you have any suggestions on how to improve this service?

- More Contact with DJO - more feedback
- Therapists be more receptive to resistant families
- DJO as co-therapist and aid in transition from DJO to therapist
- Services provided in South County. North County. etc.
- Workshops given by Black counselors
- Accept other offenses besides status, because non-status families could benefit also.

ny Criticism?

FTU only taking cooperative cases.
Court orders are disregarded if therapist disagrees with recommendation
Hearsay "FTU overstepping responsibility"
Keep worker posted more often on events and therapy
Time lag from referral to appointment. families become resistant again
Separation from original worker to therapist is difficult for client
FTU won't accept any cases but status cases
Referral didn't go to "asked for" therapist.
Lack of inclusion of DJO in treatment sessions.

An Analysis of Family Environment Scale (FES) data.*

The FES was utilized on the primary measure of family social environment since it is a scale that is consistent with the theoretical basis of Family Therapy.

There are ten subscales on this inventory. These are:

1.	Cohesion	The extent to which family members are concerned and committed to the family and the degree to which they are helpful and supportive to each other.
2.	Expressivness	The extent to which family members are allowed and encouraged to act openly and to express their feelings directly.
3.	Conflict	The extent to which the open expression of anger and aggression and generally conflictual interactions are characteristic of the family.
4.	Independence	The extent to which family members are encouraged to be assertive, self-sufficient, to make their own decisions, and to think things out for themselves.
5.	Achievement Orientation	The extent to which different types of activities (e.g., school and work) are cast into an achievement-oriented or competitive framework.
6.	Intellectual-Cultural Orientation	The extent to which the family is concerned about political, social, intellectual, and cultural activities.
7.	Active-Recreational	The extent to which the family participates actively in various recreational and sporting activities.

* The Family Environment Scale was developed by Rudolf Moos, Director, Social Ecology Laboratory, Department of Psychiatry and Behavioral Sciences, Stanford University, Stanford, California; Veterans Administration Hospital, Palo Alto, California.

8. Moral-Religious Emphasis	The extent to which the family actively discusses and emphasizes ethical and religious issues and values.
9. Organization	The extent to which order and organization are important in the family in terms of structuring of family activities, financial planning, and the explicitness and clarity of rules and responsibilities.
10. Control	The extent to which the family is organized in a hierarchical manner, the ridgity of rules and procedures, and the extent to which family members order each other around.

An overall family score is calculated for each of these subscales; similar scores were also calculated for the identified subject and his/her parents. The primary focus was on changes in the family scores. It should be noted that not all subscales were regarded as equally relevant. The following changes were predicted in subscale scores:

FAMILY SCORES:	(1) a decrease in conflict (2) an increase in cohesion
Adolescent Subjects	(1) decrease in conflict (2) increase in expressiveness (3) increase in achievement orientation
Mother	(1) decrease in conflict (2) increase in organization (3) decrease in control
Father	(1) decrease in conflict (2) increase in organization (3) decrease in control

Initially it was hoped that the FES could be given to both an experimental and a control group. Due to a number of administrative difficulties it was impossible to develop a control group. However, in the next phase of analysis a control group will be utilized. The data in this report was gathered by giving the FES scale to subjects referred to the Family Treatment Unit. These subjects were to be tested again 4 weeks and 12 weeks after treatment. Since only a limited amount of 12 week data has been

gathered, the prime comparison are between Pre-test and 4 week. T-tests for matched dependent samples were used to analyze the data. Initially 47 cases were coded, 33 of which have Pre and 4 week scores. The Pre and Post N for subject, mother and father is correspondingly 32, 31, and 19. (The smaller N for father reflects the number of fatherless families).

Some other characteristics of the sample are as follows:

Twenty-six of the identified subjects were male, 21 were female. Of the 47 cases, only 1 involved a Black family. Most subjects were in treatment 13 weeks or more. Thirty-five families were in the regular on-going family treatment, 8 were in high impact treatment and 4 were in the assessment group but never completed treatment.

Those interpreting this data should keep in mind the relatively small size of the N. Due to this fact the 10% level of probability was chosen as the rough cutting point for statistical significance. Two-Tail probability was used in all cases except where specific directional predictions were made. Standard scores were utilized for comparison. The appendix includes the Pre-test and 4 week scores for family, subject and parents on all subscales.

Comparison of Family Scores Pre and 4 Week. (Appendix - Table 1)

Three of the 10 subscales reflect a significant change in mean scores. As predicted there was an increase in the cohesion (T=1.49, 32 degrees of freedom, 1 tail p=.073). There was also a non-predicted increase in the family independence score (T=2.28, 32 dF, p=.030)

The biggest predicted change was in the family conflict score. This dropped from a mean at 56.15 at pre-test to 50.52 at 4 weeks. The pairwise difference was 5.64. (T=2.92, 32 dF 1 tail p=.003).

No other statistically significant changes occurred.

Thus the data confirms that the predicted changes occurred and are plausibly a result of the family treatment program. Further confirmation will require an analysis of the 12 week data and the development of a control or comparison group.

Comparison of Individual Scores on the FES.

Identified Adolescent Subject (Appendix: Table 2)

The identified subject showed changes in cohesion, conflict and independence (cohesion T=1.96, 31 dF p=.059; conflict T=3.60, 31 dF 1 tail p=.0005; independence T=1.74, 31 dF p=.091) similar to those of the family scores. The identified subjects also showed an increase in the active recreational score (T=2.80, 31 dF p=.009) and an increase in the moral-religion (T=3.03, 31 dF p=.005). The change in conflict was as predicted.

Relative to other predictions there was a significant increase in reported expressiveness (T=1.47 31 dF 1 tail p=.075). Achievement orientation did not significantly change.

Thus, the predicted decrease in conflict was confirmed as was the predicted increase in expressiveness. The predicted increase in achievement orientation was not confirmed. A number of other changes also occurred.

Mother (Appendix: Table 3)

The mother proved to be the individual who changed the least. However, there was a significant decrease in reported conflict (T=2.56 30 dF 1 tail p=.008) and in control (T=1.76 30 dF 1 tail p=.044) as predicted. There was an increase in the organizational score but this was not statistically significant. Two out of three predictions were thus confirmed.

Father (Appendix: Table 4)

As a group the father showed rather substantial changes across the board. Their scores show unpredicted yet significant increases in reported cohesion (T=1.96 18 dF p=.065), expressiveness (T=2.04 18 dF p=.057), independence (T=1.85 18 dF p=.081), intellectual-cultural (T=2.56 18 dF p=.02) active recreation (T=2.73 18 dF p=.014) and moral-religion emphasis (T=3.18 18 dF p=.005). Fathers also showed a predicted significant decrease in conflict (T=2.87 18 dF 1 tail p=.005).

There was a bearly significant increase in organization (T=1.32 18 dF 1 tail p=.1015) which supports a prediction. A decrease in control was not statistically significant. The statistically significant differences were found in spite of the fact that there was only 19 cases in this category. Again two out of three predictions were confirmed.

Summary of Individual Scores

These overall results tend to support the results of the family scores although they also indicate that the greatest changes are being reported by father (when present) and identified subject. Six of nine predicted changes did occur and were statistically significant.

Pre and 4 Week Cross-Sectional Comparison of Subject, Father and Mother.

(Since this data is less salient, we will simply report some general trends.) There were relatively few pairwise differences between mother and father at either pre-test or 4 weeks. Identified subjects tended to have lower expressiveness scores than either mother or father at both pre-test and 4 weeks. On the other hand, subjects reported higher achievement orientation scores than either mother or father at both time periods. In terms of pre and post testing difference on the key subscales, the only significant difference between subject, mother and father was on expressiveness.

Comparison between HIFT (higher impact) and Ongoing Treatment Program.

Comparisons were made between HIFT and ongoing groups for the ten family subscale scores at both time periods.* It should be noted that only 8 families had gone through high impact family treatment as opposed to 35 in the ongoing category. Not too many differences emerged. HIFT families reported higher levels of recreational activity at both Pre and 4 weeks. There was a near significant difference between HIFT and ongoing families at Pre-test relative to expressiveness with the former being more expressive (T=1.80 8.8 dF p=.106). This difference washed out by 4 weeks. Of more interest is the fact that at the 4 week period there was a significantly higher level of conflict in the HIFT group than in the ongoing (T=1.89 16.97 dF p=.076)

A seperate pairwise Pre-test and 4 week longitudinal comparison of the two groups revealed that the ongoing treatment form is more effective in increasing cohesion and lowering conflict while the high impact treatment is more effective in raising independence and organizational scores.

Given the brevity of the treatment in the HIFT condition, the relatively small number of differences between HIFT and ongoing is encouraging. However, the significantly higher level of conflict in HIFT is the post-test should be a cause for some concern.

* T-test for these comparisons were based on groups rather than pairs.

OVERALL SUMMARY OF FINDING

These tentative data seem to indicate that the Family Treatment Unit has been effective in lowering the rate of juvenile referrals to court after point of contact. As measured by FES, it has produced an increase in family cohesion and independence and a decrease in conflict.

For adolescents the predicted change in conflict and expressiveness were confirmed. The prediction about achievement orientation was not confirmed.

For both parents, it was predicted that there would be a decrease in conflict, an increase in organization and a decrease in control. Mothers showed a significant decrease in conflict and control but no significant change in organization. Fathers on the other hand showed a significant change in conflict and organization but not in control as measured by the FES; 8 of 11 predictions were confirmed. A number of other non-predicted but interesting changes also occurred.

Thus at this point in time, the data shows that a number of important changes are occurring in the families and that there changes are most likely the result of contact with the family treatment unit.

APPENDIX TABLE 1

Mean FES Scores - Family
(standard scores) N=32

* = 1 tail probability
2 tailed
T-test
of Difference

Subscales	Pre-test	4 Week	
Cohesion	35.30	37.73	.073*
Expressiveness	39.58	40.39	.613
Conflict	56.15	50.52	.003*
Independence	38.36	44.30	.030
Achievement-Orientation	47.82	49.03	.446
Intellectual-Cultural	37.61	37.61	1.00
Active Recreational	36.73	38.12	.355
Moral-Religion	48.76	50.00	.457
Organization	44.73	45.45	.606
Control	52.78	50.94	.305

TABLE 2

Mean FES Scores - Adolescent Subject
(standard scores) N=32

* 1 tail probability

Subscales	Pre-Test	4 Week	2 tailed T-Test of Difference
Cohesion	33.09	36.97	.059
Expressiveness	35.94	39.44	.075*
Conflict	58.00	52.09	.0005*
Independence	37.59	43.63	.091
Achievement Orientation	51.63	53.50	.150*
Intellectual Cultural	35.44	34.47	.550
Active Recreational	35.69	40.75	.009
Moral-Religion	46.75	49.91	.005
Organization	46.13	46.72	.653
Control	53.63	54.38	.687

TABLE 4

Mean FES Scores - Father
(standard scores) N=19

* = 1 tail probability

Subscale	Pre-test	4 Week	2 tailed T-test of Difference
Cohesion	33.68	39.63	.065
Expressiveness	38.95	44.95	.057
Conflict	57.37	49.79	.005*
Independence	40.63	46.63	.081
Achievement-Orientation	43.79	46.16	.360
Intellectual Cultural	33.73	39.26	.020
Active Recreational	32.58	37.63	.014
Moral-Religion	47.58	51.58	.005
Organization	43.03	46.21	.1015*
Control	53.21	51.47	.249*

FAMILY TREATMENT UNIT

INSTRUCTIONS FOR REFERRAL FORM

Please read the instructions below for filling out the Family Treatment Unit Referral Form. Included in this package are the following: 1) Referral Form, 2) DJO Questionaire Form, 3) Consent Form, 4) Jesness Behavior Checklist.

In order to process your referral, we need all of the above filled out before you turn in your referral. We have discontinued the "Adolescent Behavioral Inventory" and have replaced it with the Jesness Behavior Checklist. The Jesness Behavior Checklist can be filled out when you meet with the family to discuss the Family Treatment Unit with them. They are not to take it home with them. Because we have eliminated the "Adolescent Behavioral Checklist" which was to be worked on at home for two weeks before the family could be seen, we are now able to contact the family immediately after receiving the referral.

1. Fill Out Referral Form Completely.

2. Fill Out DJO Questionaire

3. When you meet with the family to discuss Family Treatment give them the Jesness Behavior Checklist and have one of the parents fill it out. (This is replacing the "Adolescent Behavioral Inventory").

4. Have Family sign the Consent Form for Research.

5. Return Referral Form, DJO Questionaire, Jesness Behavior Checklist, and Consent Form for Research to the Family Treatment Unit at the time you make your referral.

6. The family will be contacted immediately after your referral is accepted.

We appreciate your cooperation.

FAMILY TREATMENT UNIT

FAMILY TREATMENT UNIT

Referred by_____

I. Child's Name_____ Sex_____

Birthdate_____ Juvenile #_____

Address_____ Phone_____

School_____ Grade_____

School Placement ( ) Reg. ( ) E.M.R. ( ) BD ( ) LD

II. COURT INVOLVEMENT

A. Nature of Incident _____

_____

_____

_____

_____

B. PREVIOUS COURT INVOLVEMENT _____

_____

_____

_____

C. REASON FOR REFERRAL TO FAMILY TREATMENT UNIT _____

_____

_____

_____

_____

D. HAVE YOU DISCUSSED THIS WITH THE FAMILY _____

_____

_____

_____

E. WHAT IS THE ATTITUDE OF FAMILY TOWARDS INVOLVEMENT IN FAMILY THERAPY

_____

_____

_____

III. FAMILY CONSTELLATION

Names	Age	Employment	Previously Married
Father:			
Mother:			

Years Married _____

Siblings	Age	Sex	Court Involvement

Other Members Living In Household _____

IV. FAMILY CHARACTERISTICS INVENTORY

	Does Not Fit Family 1	2	Fits Family Some 3	4	Fits Family Well 5
1. Family does not talk things out					
2. There is an opportunity for each member to express him/herself					
3. Family does not do things together					
4. Family respects each other's feelings					
5. Discipline is not moderate and consistent					
6. There is a sense of belonging in this family					
7. Educational goals are important					
8. Family has many friends					

V. PREVIOUS INVOLVEMENT WITH OTHER AGENCIES _____

DJO QUESTIONAIRE

FAMILY NAME_____ NAME OF CHILD_____

1. How many contacts have you had with the family over the last month?_____

   Who initiated the contact?_____

2. Is the child viewed as the only problem in the family? ____Yes ____No

3. How well does this family deal with problems or crises?

   1 2 3 4 5
   very rarely quite frequently

4. Does this family talk things out?

   1 2 3 4 5
   very rarely quite frequently

5. Does the child seek parental support/help?

   1 2 3 4 5
   very rarely quite frequently

6. How sensitive are the parents to the child's needs?

   1 2 3 4 5
   very rarely quite frequently

7. Do parents agree with each other on how to raise the child?

   1 2 3 4 5
   very rarely quite frequently

8. Are both parents equally involved in raising the child?

   1 2 3 4 5
   very rarely quite frequently

9. How frequent are fights in the family?

   1 2 3 4 5
   very rarely quite frequently

10. Family does activities jointly.

    1 2 3 4 5
    very rarely quite frequently

Case # _____
(leave blank)

JESNESS BEHAVIOR CHECKLIST

Family Last Name: _____ Date: _____

Name of Child: _____ Age: ____ Sex: ____ Male ____ Female

Filled Out By: (Please Check One) ___Mother ___Father ___Mother & Father

INSTRUCTIONS

The purpose of this checklist is to provide a way of recording behavior. In making your ratings, think of the child as he or she has been during the past month.

Read each statement and decide whether the child behaves in the stated manner very often, often, fairly often, not often, or almost never. Mark with an "X" in only one category for each statement.

Mark the response which most nearly represents your evaluation, on this paper.

Please be sure to respond to all items.

JESNESS BEHAVIOR CHECKLIST

Almost Never	Not Often	Sometimes	Fairly Often	Very Often	
					1. Interrupts or distracts others
					2. Has been seen to compliment or encourage others.
					3. Is involved in clowning, horseplay, inappropriate behavior.
					4. Tries to get others into trouble. Instigates arguments and fights, or calls attention to behavior of others.
					5. Seeks advice or help from others at times when he should.
					6. Poor sport. Cheats to win, shows anger or sulks when losing.
					7. Goes out of his way to say hello or speak to others, even those less popular.
					8. Agitates, teases, laughs at, or ridicules others.
					9. Is well-groomed, clean, and neat in appearance.
					10. Apologizes when appropriate.
					11. Picks on, pushes around, threatens, or bullies those around him.
					12. Makes appropriate responses to others; speaks when spoken to, smiles when others smile at him, etc.
					13. Brags about or delights in describing antisocial, unlawful, delinquent, or criminal exploits.
					14. Fails to become quiet or calm down when requested to do so.
					15. Can express difference of opinion, criticism, or complaint without antagonizing.
					16. Upset if he can't have or do something right now.
					17. Is excessively loud and noisy at inappropriate times or places.
					18. Helps others, even without apparent personal gain.
					19. Is involved in quarreling, squabbling, bickering.
					20. Schoolwork or job assignments are done neatly and carefully.
					21. When corrected, shifts blame, makes excuses, or complains that it is unfair, etc.
					22. Is assertive. Makes his opinions and preferences known.

JESNESS BEHAVIOR CHECKLIST

Almost Never	Not Often	Sometimes	Fairly Often	Very Often	
					23. Takes good care of his own and others' equipment and property.
					24. Show disdain for group or individual counseling sessions.
					25. Gets things done; does a lot of work in a given time.
					26. Can be talked into things; goes along with others.
					27. Is not easily discouraged. Sticks with and completes tasks assigned.
					28. Rewards or encourages (with attention, approving gestures, remarks, et delinquent or antisocial behavior of others.
					29. Can make routine decisions without undue hesitation or soliciting help from others.
					30. Gets up on time, gets to school or work on time, etc.
					31. Complains about or expresses low opinion of counselors, police, or other authority figures.
					32. Shows initiative: goes ahead to next task, makes good use of free time etc.
					33. Asks for help or seeks assistance, even on simple tasks.
					34. Has assumed the responsibility for organizing, and/or supervising the actions of others of his age group in accomplishing a work or recreational task.
					35. Actively resists authority: argues with decisions and complains when told what to do.
					36. Begins or attends to routine assignments or chores without reminders.
					37. Turns to someone such as a teacher or counselor to take care of his problems with others.
					38. Gets school and/or work assignments done on time.
					39. Is difficult to understand (speech is mumbled or incoherent).
					40. Tells the truth; does not lie, exaggerate, or fabricate.
					41. Becomes anxious, upset, and/or freezes when frustrated, under pressure, or faced with a difficult task.
					42. Takes an active, contributing part in group discussions and/or meeting
					43. Steals or takes things without permission.

JESNESS BEHAVIOR CHECKLIST

Almost Never	Not Often	Sometimes	Fairly Often	Very Often	
					44. Listens carefully to instructions or explanations.
					45. Appears nervous, anxious, jittery, or tense.
					46. Can be relied upon to do what he says he will do.
					47. Becomes hurt or anxious if criticized.
					48. Requests or questions are direct and straightforward.
					49. Uses profanity or vulgar language.
					50. Can take kidding or teasing without becoming upset or anxious.
					51. Displays personal habit(s) or behavior(s) that is aberrant, offensive, or disturbing to others.
					52. Tells others about being nervous, unable to sleep, etc.
					53. Looks at the person he is talking to.
					54. Does things that are wrong, illegal, or against the rules.
					55. Makes positive statements about himself (demonstrates positive self-concept).
					56. Gravitates toward a delinquent-type group or clique.
					57. Is slow to respond to requests.
					58. Becomes depressed or withdrawn when frustrated or criticized.
					59. Is well-liked; sought out by others of his age group.
					60. Is short-tempered and quick to show anger.
					61. Talks freely to persons such as counselors or teachers about himself (his plans, his problems, etc.).
					62. Is slow moving, sluggish, listless, spiritless, etc.
					63. Gets along with others in group recreation.
					64. Tends to avoid persons such as teachers, therapists, and counselors or any activities in which they take part.
					65. Is cheerful. Laughs and smiles.
					66. Becomes aggravated or abusive when frustrated or his will is opposed.

JESNESS BEHAVIOR CHECKLIST

Almost Never	Not Often	Sometimes	Fairly Often	Very Often	
					67. Works cooperatively with others in work or task groups.
					68. Gets into physical fights.
					69. Seeks out friendly conversations with adults.
					70. Tends to withdraw and/or isolate himself from others.
					71. Accepts criticism or teasing without flaring up or becoming angry.
					72. Is the recipient of ridicule, agitation, etc.
					73. Takes part in social events and tries to get involved in group functi and activities.
					74. States or demonstrates that he distrusts persons in authority such as teachers, counselors, therapists, etc.
					75. Actively engages in problem-solving behavior related to personal, fam or social problems.
					76. Appraises his own abilities and accomplishments realistically.
					77. Plans realistically for his vocational or academic future.
					78. Understands (can verbalize) how to avoid trouble with school official police, or other authorities.
					79. Verbalizes realistic understanding of ways and means of coping with parents and/or home situations.
					80. Actively engages in problem-solving behavior related to deciding upon and achieving future objectives.

PROJECT F.T.U.

CONSENT FORM FOR RESEARCH

As a participant in the Family Unit, I understand that any material obtained by the staff of the project can also be used for research. I would also be willing to provide information on my child's progress after he leaves. However, I realize that my name will be excluded when used for research to insure confidentiality.

Signed: _____
Child

_____
Parent/Guardian

_____ _____
Parent/Guardian

Date: _____

CASE #_____
(leave blank)

FAMILY ENVIRONMENT SCALE

Family Last Name:_____ Date Filled Out_____

Name of Child:_____ Age:____ Sex: Male__ Female__

Your Relationship to Child: (PLEASE CHECK ONE OF THE BELOW)

Mother____ Father ____ Child ____ Brother ____ Sister ____

Other _____(Fill in Relationship such as aunt, grandfather,

If you are a brother or sister, fill out below:

Your name_____ Your age_____

INSTRUCTIONS

There are 90 statements in this booklet. They are statements about families. You are to decide which of these statements are true of your family and which are false.

True - Circle the T when you think the statement is <u>True</u> or mostly <u>True</u> of your family.

False - Circle the F when you think the statement is <u>False</u> or mostly <u>False</u> of your family.

You may feel that some of the statements are true for some family members and false for others. Circle T if the statement is <u>true</u> for most members. Circle F if the statement is <u>false</u> for most members. If the members are evenly divided, decide what is the stronger overall impression and answer accordingly.

Remember, we would like to know what your family seems like to you. So do <u>not</u> try to figure out how other members see your family, but do give us your general impression of your family for each statement.

PLEASE DO NOT LEAVE ANY STATEMENTS UNMARKED.

T F 1. Family members really help and support one another.

T F 2. Family members often keep their feelings to themselves.

T F 3. We fight a lot in our family.

T F 4. We don't do things on our own very often in our family.

T F 5. We feel it is important to be the best at whatever you do.

T F 6. We often talk about political and social issues.

T F 7. We spend most weekends and evenings at home.

T F 8. Family members attend church, synagogue, or Sunday School fairly oft

T F 9. Activities in our family are pretty carefully planned.

T F 10. Family members are rarely ordered around.

T F 11. We often seem to be killing time at home.

T F 12. We say anything we want to around home.

T F 13. Family members rarely become openly angry.

T F 14. In our family, we are strongly encouraged to be independent.

T F 15. Getting ahead in life is very important in our family.

T F 16. We rarely go to lectures, plays or concerts.

T F 17. Friends often come over for dinner or to visit.

T F 18. We don't say prayers in our family.

T F 19. We are generally very neat and orderly.

T F 20. There are very few rules to follow in our family.

T F 21. We put a lot of energy into what we do at home.

T F 22. It's hard to "blow off steam" at home without upsetting somebody.

T F 23. Family members sometimes get so angry they throw things.

T F 24. We think things out for ourselves in our family.

T F 25. How much money a person makes is not very important to us.

T F 26. Intellectual curiosity is very important in our family.

T F 27. Nobody in our family participates actively in sports, Little League, bowling, etc.

T F 28. We often talk about the religious meaning of Christmas, Passover, or other holidays.

T F 29. It's often hard to find things when you need them in our household.

T F 30. There is one family member who makes most of the decisions.

T F 31. There is a feeling of unity and cohesion in our family.

T F 32. We tell each other about our personal problems.

T F 33. Family members hardly ever lose their tempers.

T F 34. We come and go as we want to in our family.

T F 35. We believe in competition and "may the best man win."

T F 36. We are relatively uninterested in cultural activities.

T F 37. We often go to movies, sports events, camping, etc.

T F 38. We don't believe in heaven or hell.

T F 39. Being on time is very important in our family.

T F 40. There are set ways of doing things at home.

T F 41. We rarely volunteer when something has to be done at home.

T F 42. If we feel like doing something on the spur of the moment we often just pick up and go.

T F 43. Family members often criticize each other.

T F 44. There is very little privacy in our family.

T F 45. We always strive to do things just a little better the next time.

T F 46. We rarely have intellectual discussions.

T F 47. Everyone in our family has a hobby or two.

T F 48. Family members have strict ideas about what is right and wrong.

T F 49. People change their minds often in our family.

T F 50. There is a strong emphasis on following rules in our family.

T F 51. Family members really back each other up.

T F 52. Someone usually gets upset if you complain in our family.

T F 53. Family members sometimes hit each other.

T F 54. Family members almost always rely on themselves when a problem comes up.

T F 55. Family members rarely concern themselves about job promotions, school grades, etc.

T F 56. Someone in our family plays a musical instrument.

T F 57. Family members are not very involved in recreational activities outside work or school.

T F 58. We believe there are some things you just have to take on faith.

T F 59. Family members make sure their rooms are neat.

T F 60. Everyone has an equal say in family decisions.

T F 61. There is very little group spirit in our family.

T F 62. Financial matters are openly discussed in our family.

T F 63. If there's a disagreement in our family, we try hard to smooth things over and keep the peace.

T F 64. Family members strongly encourage each other to stand up for their rights.

T F 65. In our family, we don't try that hard to succeed.

T F 66. Family members often go to the library.

T F 67. Family members sometimes attend courses or take lessons for some hobby or interest (outside of school).

T F 68. In our family each person has different values or standards of right and wrong.

T F 69. Each person's responsibilities are clearly defined in our family.

T F 70. We can do whatever we want to in our family.

T F 71. We really get along well with each other.

T F 72. We are usually careful about what we say to each other.

T F 73. Family members often try to one-up or out-do each other.

T F 74. It's hard to be by yourself without hurting someone's feelings in our household.

T F 75. "Work before play" is the rule in our family.

T F 76. Watching T. V. is more important than reading in our family.

T F 77. Family members go out a lot.

T F 78. The Bible is a very important book in our home.

T F 79. Financial planning, budgeting and allowances are not handled very carefully in our family.

T F 80. Rules are pretty inflexible in our household.

T F 81. There is plenty of time and attention for everyone in our family.

T F 82. There are a lot of spontaneous discussions in our family.

T F 83. In our family, we believe you don't ever get anywhere by raising your voice.

T F 84. We are not really encouraged to speak up for ourselves in our family.

T F 85. Family members are often compared with others as to how well they are doing at work or school.

T F 86. Family members really like music, art, and literature.

T F 87. The main form of entertainment in our family is watching T.V. or listening to the radio.

T F 88. Family members believe that if you sin you will be punished.

T F 89. Dishes are usually done immediately after eating.

T F 90. You can't get away with much in our family.

FAMILY ASSESSMENT

Name: [redacted]
DOB: 11/24/62
Parents: [redacted]
DJO:
Date: 6/21/79

I) This family was referred to the Family Treatment Unit by . DJO. Ms. came in contact with this family through the 16 year old daughter, Valerie. Valerie had been reported as a runaway a few times. The most recent elopment was on 6-12-79. Ms. expressed the thought that Valerie prefers to runaway than face any problems at home.

II) I met with Valerie and Mr. and Mrs. on an emergency basis after Valerie had been located from this last elopement. After two hours of crises Intervention Mr. and Mrs. and Valerie returned to their home. Valerie made a committment that she would not runaway.

My second contact with this family was with Valerie, individually. In this session a more supportive relationship was established between Valerie and myself, and her committment to work things out and not run was reinforced.

The third contact was a session with Mr. and Mrs. , Valerie (16), Dale (14), and Kurt (19). (There are two other family members; Cindy (20) and Elaine (21), who were not present at the session. All the members living together, however, were present. Cindy and Elaine are on their own. Cindy has been married and divorced and is married again.)

III) Initially the family was able to identify the following problems: family members are too "closed", the rules at home aren't really clear, rules aren't enforced with appropriate and/or consistent consequences, Valerie needs to change some of her associates.

Mr. and Mrs. shared that they have been separated in the past and did participate in marital therapy at a Catholic Family Agency. Through their experience there they decided to stay together. They also mentioned that their daughter, Cindy, had lived with them during the period connected with her divorce. The other daughter, Elaine, was also living at home for a span of that time. They report that their own marital difficulties, plus the period of time when they were dealing with their daughter's problems, plus the "overcrowded" situation at home when all seven members were together again were bound to have contributed to the current "problem" with Valerie.

IV) In my opinion the following dysfunctions and dynamics are operating at this time with the family. Mr. in the recent past has changed from being a strict disciplinarian to a much less strict disciplinarian. Mrs. Nordman has become more strict (role reversal?). This has caused the siblings, especially Valerie, to not know exactly what to do. So, basically they have tried doing what they wanted to do. Family members are disengaged from each other - i.e. They are distant from each other having/showing little emotional involvement and/or support to each other. Generational boundaries are being violated by cross-generational coalitions i.e.- When mother and father disagree - Kurt may side with Dad or Valerie with Mom against Dad. Consequently there is little conflict resolution in this family because of these coalitions which detour conflict.

Name: . Valerie
DOB: 11/24/62
Parents:
DJO:
Date: 6/21/79

V) Therapy will consist of balancing Mr. and Mrs. participation in setting and enforcing rules (getting Dad to take a more active part, Mom backing off some), stopping unhealthy coalitions from operating, encouraging family members to become a little more open and supportive of each other - especially getting Mom and Dad to work together and the siblings to work together (separating parental/sibling subsystem), and lastly, if therapy continues, to help Mr. and Mrs. bring some closure to the unfinished issues/conflicts in their marital relationship.

M.S.W.
FAMILY TREATMENT UNIT

Family Assessment

Name: Elizabeth (Beth)
DOB: 11-18-64
Parents:
DJO:
Date: 7/19/79

I) This family was referred to the Family Treatment Unit by Ms. came in contact with this family through Beth (14). Apparently the referrals concerning Beth involve extreme incorrigibility. Beth has been hospitalized two different times in the last year - once for 39 days and a second time for 69 days. She was hospitalized for her uncontrollable behavior. During the hospitalization she was under psychiatric care which had little or no impact on her inappropriate behavior.

II) I met with M/M and Beth. There are three older siblings in this family: Kevin (25), Diana (22), and David (21). These three siblings are married, live away from home, and were not present in this initial session.

III) Mr. reported the following problems. He said that Beth does not respect anyone. She uses profanity constantly. She is physically abusive and aggressive. She won't keep her room clean. She won't do any chores at home. She generally is difficult to get along with.

Mrs. y agreed that those things were indeed problems. She also stressed the fact that Beth's school attendance and performance was a main problem. Mrs said Beth does what she wants to when she wants to - irregardless of what M/M y say or do.

Beth reported that the main problem was other people "butting into (her) business" when she just wants to be let alone to do what she wants to do.

M/M further stated that they were afraid of what Beth might do, and that they have tried a number of different resources to get help for themselves and Beth - all to no avail.

IV) In my opinion the following dysfunctions and dynamics are operating at this time within this family. Generational boundaries are not clear. There is little order or hierarchy in this system. The parental, sibling, and marital subsystems are not clearly defined.

M/M have seemingly given up their position as parents. They have allowed Beth to take a position equal to their's in the family. Beth has cooperated with this and struggles for power with aggressive, disrespectful, inappropriate behaviors.

It seems also that the two periods of hospitalization have reinforced Beth's position as the "sick-one" or scapegoat of this system. It is similar to a self-fulfilling-prophecy. Beth is living up to her stereotyped position in this family.

Name: Elizabeth (Beth)
DOB: 11/18/64
Parents:
DJO:
Date: 7/19/79

These three family members have little skill to resolve conflicts. They have tried a number of different solutions - but the results have always been the same - just more of the same with no change. Conflict continues to be detoured with no resolution.

V) Therapy will consist of the following.Generational and subsystem boundaries will be made clear. M/M ✓ will be assisted in taking control of their position as parents. Clear rules and consistent enforcement of consequences will be established - helping Beth to take a more appropriate role-i.e. that of a daughter.

Through reframing Beth (hopefully) will be moved out of her position as a scapegoat or "crazy" member of the family.

Conflict resolution skills will be modeled. Family members will be encouraged to be more supportive of each other. Lastly, marital conflict will be dealt with - stopping inappropriate detouring.

M.S.
FAMILY TREATMENT UNIT

grad 1/24

FAMILY ASSESSMENT

Name: Cynthia L.
DOB: 7-25-65
Parent:
DJO:
Date: 7-11-79

1) This family was referred to the Family Treatment Unit by DJO. Mr. ; came in contact with this family because Cindy had been running away from home frequently, and had been truant from school.
2) I had a number of contacts with this family by phone, before we met in my office. I attempted to schedule appointments a number of times but Ms. could not be reached. I found out later that she was hospitalized a couple of weeks because of her "nerves". After a great deal of resistance, an appointment was finally scheduled. At this time Cindy was placed in Shelter Care. Ms. and her family did not keep the appointment. Seemingly she felt that since Cindy was in Shelter Care and not under foot that she had no real reason to meet i.e she (Ms.) was enjoying the vacation from her responsibility as a parent.

Another appointment was scheduled after Cindy was released from Shelter Care. This was the only face-to-face contact that I have had with the family so far. Present in this session were Ms. , Rick (15), and Cindy.
3) The family members identified the following problems. Ms. stated that Cindy refused to do her chores at home. Ms. felt that Cindy has the attitude that she can come and go as she pleases. Ms. felt that another problem was that Cindy wanted too much attention from her. She thinks that both Rick and Cindy don't appreciate what she does for them (provide them with food, clothing, shelter). She wants more cooperation and less back talk.

Rick shared that the main problem he saw was that Cindy tries to be "tough".

Cindy said that she didn't want to talk about anything. She went on, however, to relate that one problem for her was her mother's boyfriend. She absolutely does not like him. She also said that she felt her mother really did not care about her.
4) In my opinion the following dysfunctions/dynamics are operating at this time in this family. Ms. s has worked hard to get where she is. She was recently hospitalized for "nerves" and is taking pain killers and tranquilizers. She is not working and is drawing some kind of compensation due to her hospitalization. All of these things together make her feel resentful about her parental role.

She has so many conflicts of her own (confusion) that it is a burden for her to provide Cindy with what she needs (mothering). Generational boundaries and roles are further confused by the presence of Mrs. 'boyfriend. He, at times, apparently tries to exert some parental authority with the children and it just escalates their disrespect and/or resentment. Cindy especially does not know how she should relate to him and what role he is in.

There is a lack of emotional support among the members of this family. It seems as if they are disengaged or disjointed from each other. There is little cohesiveness. The family rules are unclear, and enforcement of consequences is inconsistent.
5) Therapy will consist of the following. Generational boundaries and role functions will be made clear. Family members will be encouraged to be more supportive and understanding of each other's feelings (communication?). Cindy's inappropriate behavior will be reframed as needing help from Ms. and Rick - hopefully drawing a clearer more functional boundary between the parental and sibling subsystems. Consistent rules and consequences will be developed and implemented. Ms. . will be assisted in sorting through her anger and confusion so that

DOB: 7-25-65
Parent: Francine
DJO:
Date: 7-11-79

she can adequately parent her children, and the acting-out behavior (especially Cindy's) will be extinguished.

[redacted]
Family Treatment Unit

7/23